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EXCEEDINGLY EFFECTIVE "... The 85.1% incidence of effectiveness with the 400 mg. dose has exceeded the analgesic effectiveness of any other analgesic agent which we have studied to date, either alone or in combination. . . . The utilization of higher doses for short periods of time indicates that the medication has a large therapeutic range, and this is reflected in the high incidence of effectiveness and low likelihood of untoward reactions.

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DOSAGE: One capsule at onset of pain, followed by 1 capsule at intervals of 1 to 4 hours, as needed.

REFERENCES: From the Symposium, *Recent Concepts of Pain and Analgesia*, held in the Hall of States, American Hospital Association, Chicago, February 15, 1961: 1. Batterman, R. C.: *Non-Narcotic Analgesia in Ambulatory Patients.* 2. O'Dell, T. B.: *Experimental Parameters in the Evaluation of Analgesics.* 3. Miller, L. D.: *Distribution, Excretion and Metabolic Fate of Phenyramidol.* 4. Beisler, E.: *Preliminary Report of Experience with Phenyramidol for Dental Analgesia.* 5. Bader, G.: *Preliminary Report on the Use of Analexin for Dysmenorrhea in Telephone Operators.* 6. Taylor, S. L.: *Phenyramidol in General Hospital Orthopedics.* 7. Bodi, T.: *Pain Management Among Clinic Outpatients.* 8. Ramunis, J.: *Experience of an Industrial Surgeon with Phenyramidol.* 9. Kast, E. C.: *Methodological Considerations in the Clinical Evaluation of an Analgesic.* 10. Collopy, C. T.: *Preliminary Comparisons of Two Non-Narcotic Analgesic Agents in Hospitalized Orthopedic Patients.* 11. Cass, L. J.: *Report on the Analgesic and Calmative Effectiveness of Two Preparations on Patients with Acute and Chronic Pain.* 12. Lamphier, T. A.: *Intravenous Phenyramidol in the Management of Low Back Pain and Allied Disorders.* 13. O'Dell, T. B.: Chicago Med. *63*:9, 1961. 14. Kast, E. C.: Chicago Med. *63*:17, 1961. 15. Wainer, A. S.: J. Am. M. Women's A. *16*:218, 1961. 16. Batterman, R. C.: Ann. New York Acad. Sc. *86*:203, 1960. 17. O'Dell, T. B.: Ann. New York Acad. Sc. *86*:191, 1960. 18. O'Dell, T. B., *et al.:* J. Pharmacol. & Exper. Therap. *128*:65, 1960. 19. O'Dell, T. B., *et al.:* Fed. Proc. *18*:1694, 1959. 20. Gray, A. P., *et al.:* J. Am. Chem. Soc. *81*:4347, 1959. 21. Wainer, A. S.: Clin. Med. *7*:2331, 1960. 22. Clinical data in files of Medical Dept., Irwin, Neisler & Co., 1959. 23. Batterman, R. C., *et al.:* Am. J. Med. Sc. *238*:315, 1959.

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The Bulletin of The New York Academy of Medicine, Vol. 37, No. 10, October, 1961. Published Monthly by The New York Academy of Medicine, 2 East 103 Street, New York 29, N. Y. Entered as second-class matter February 3, 1928, at the Post Office at New York, N. Y., under the act of August 24, 1912. Postage paid at New York, N. Y. Annual subscription United States and Canada $8.00. All other countries $9.00. Single copies 90c.

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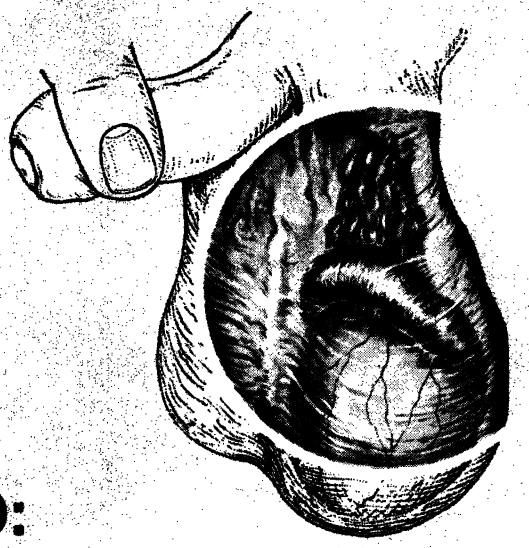

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1. Billow, B.W.; Cabodeville, A. M.; Stern, A.; Palm, A.; Robinson, M., and Paley, S. S.: Southwestern Med. *41*:286, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960.

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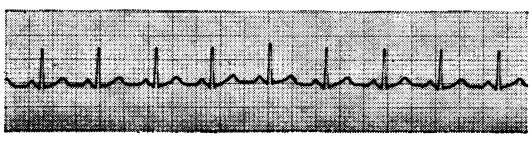

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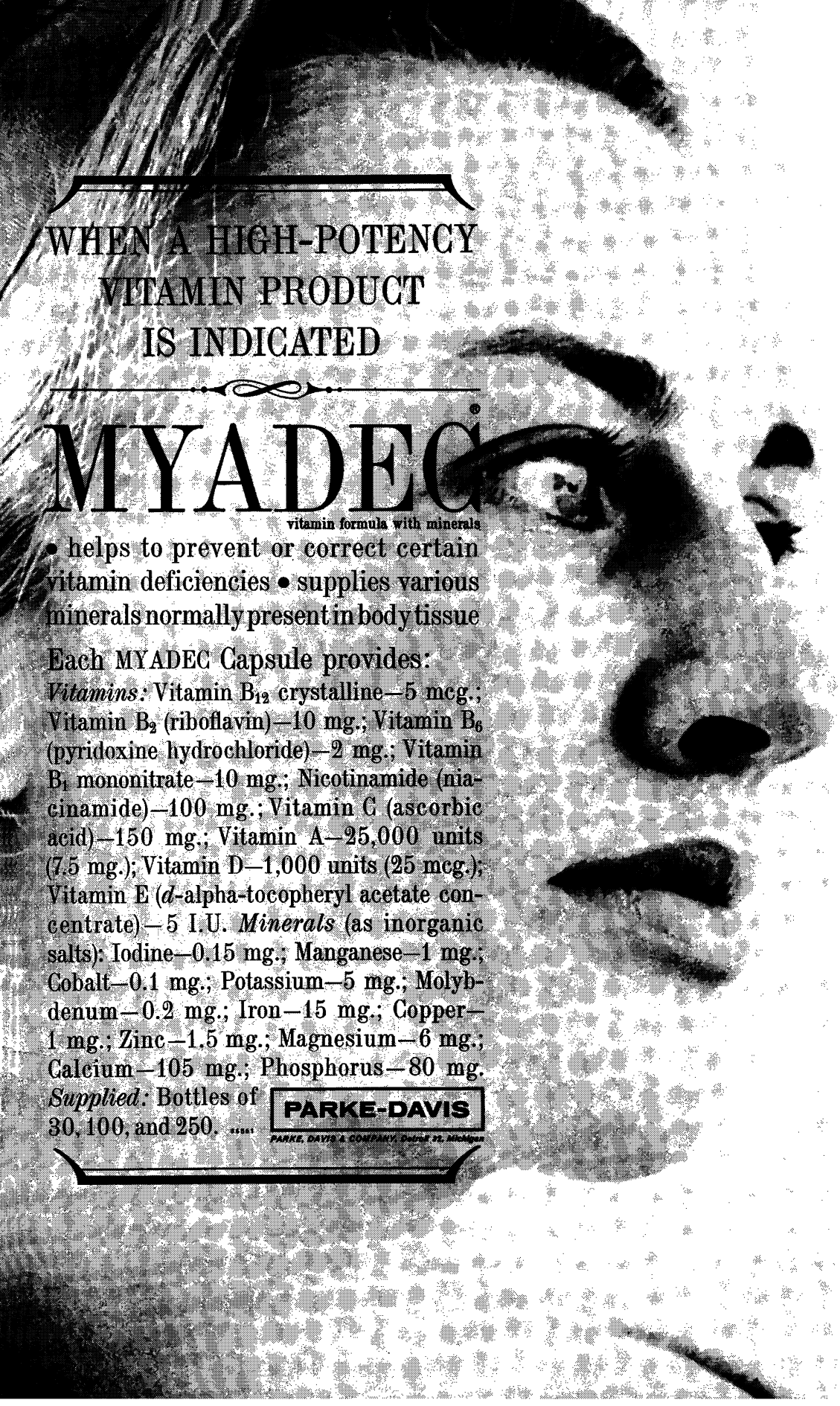

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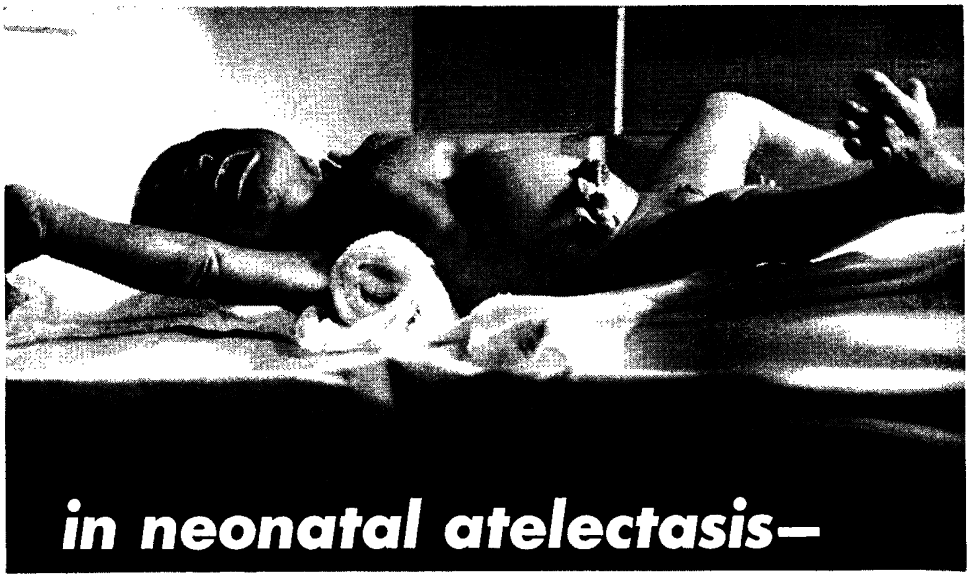

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Alevaire is supplied in bottles of 60 cc. for intermittent therapy and bottles of 500 cc. for continuous inhalation therapy. Alevaire should not be diluted. Alevaire solution is ready for use in a concentration optimal for fine droplet stability and therapeutic efficiency.

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1. Smessaert, Andre; Collins, V. J., and Kracum, V. D.: *New York J. Med.* 55:1587, June 1, 1955.
2. Banyai, A. L.: *Geriatrics* 14:621, Oct., 1959.

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Newman[1] has reported an experience which illustrates the gratifying nutritional progress physicians[2,3] often find when they prescribe Nilevar. He states:

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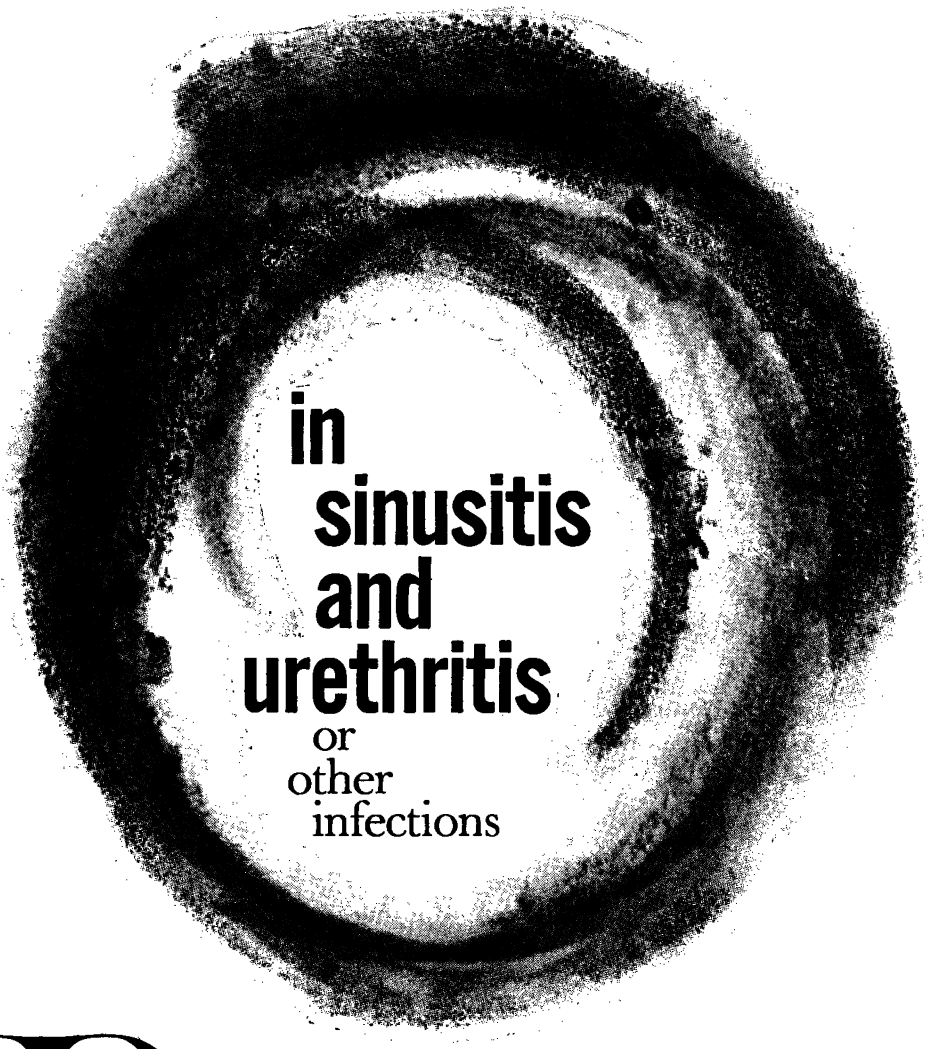
1. Newman, E. V.: Proceedings of a Conference on the Clinical Use of Anabolic Agents: Discussion, Chicago, Searle Research Laboratories, 1956, p. 44.

2. Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

3. Watson, R. N.; Bradley, M. H.; Callahan, R.; Peters, B. J., and Kory, R. C.: A Six-Month Evaluation of an Anabolic Drug, Norethandrolone, in Underweight Persons: 1. Weight Gain, Am. J. Med. 26:238 (Feb.) 1959.



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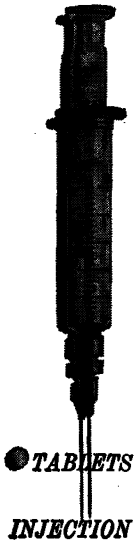

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*Some depressed patients respond within 5 to 10 days, while others may require up to two weeks or longer to obtain benefit.

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- a single agent (not a combination of compounds)
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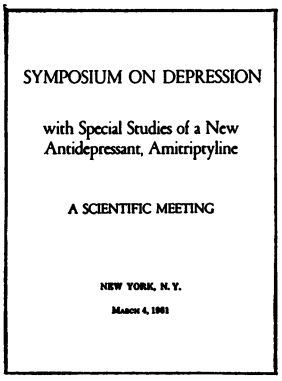


EXCERPTS FROM A SYMPOSIUM ON DEPRESSION

ELAVIL®

AMITRIPTYLINE HYDROCHLORIDE

INVESTIGATOR	FINDINGS
DUNLOP, EDWIN: The treatment of depression in private practice.	"Amitriptyline [ELAVIL] has a specific advantage over any antidepressant currently available and I see increasing evidence of its usefulness in reducing tension, agitation and anxiety, as well as in relieving the depressive quality of the illness. Amitriptyline appears... to combine better than any other antidepressant drug the successful treatment of anxiety at one end of the scale and depression at the other. Experience in the past has shown us that, when using electroshock or analeptics, although depression can be relieved, the accompanying anxiety eventually proves more troublesome than the depressive phase of the illness. Amitriptyline successfully bridges these divergent symptoms which are displayed in varying proportions in all depressive syndromes. "...Approximately one hundred and twenty patients have been studied with amitriptyline during the last fifteen months. It is an effective antidepressant when employed in both hospital and ambulatory patients. Its dependability and freedom from toxicity and severe side effects merit further evaluation on a broader spectrum of depressive disorders."
BENNETT, DOUGLAS: Treatment of depressive states with amitriptyline.	"In those cases showing a good response, early and dramatic improvement in sleeplessness resulted and many patients noted a feeling of relaxation. The ability of some patients to reduce their night sedatives after only a month's treatment was unique in my experience of the treatment of depression."
SAUNDERS, JOHN C.: Antidepressives: the pith of affective therapy.	"Its primary action in hospitalized psychotics is antidepressive; this along with its very low rate of side actions make it a drug of potentially frequent application in a broad spectrum of neuropsychiatric diseases.... Since a large part of any hospital population will reach a plateau if given only a tranquilizer or an energizer, we suggest that amitriptyline alone be given prior to combination therapy, as this drug is easier and safer to administer and produces a significant improvement in a high percentage of cases (60-75)."
OSTFELD, ADRIAN M.: Effects of an antidepressant drug on tests of mood and perception.	"Finally, it appears that amitriptyline in the doses employed here is relatively effective in depressed states of neurotic proportions. Its freedom from severe side effects in doses that are therapeutically effective seems established in this patient population."

(This symposium was published in
Diseases of the Nervous System,
Volume 22, Section Two—Supplement, May 1961)

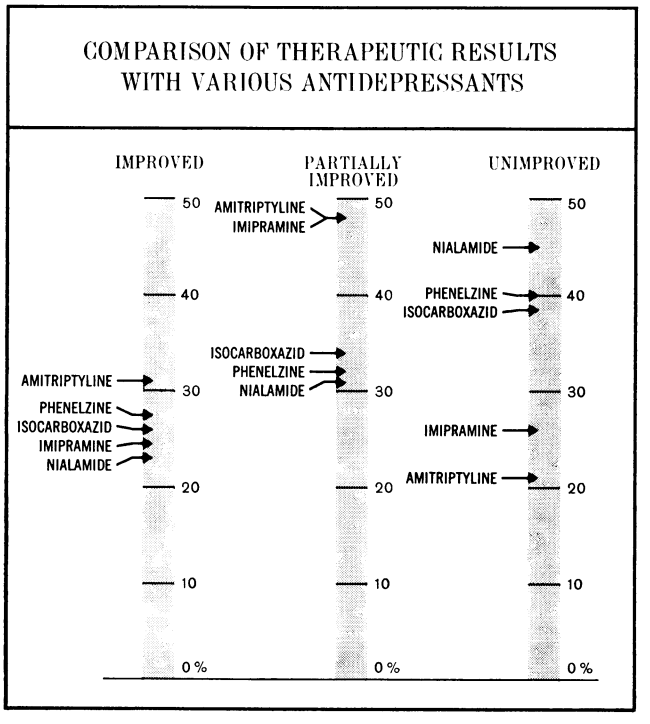
INVESTIGATOR

AYD, FRANK J., JR.:
A critique of
antidepressants.

FINDINGS

"Amitriptyline and imipramine induce similar side effects but, generally speaking, those of amitriptyline cause less subjective discomfort in patients than those of imipramine.

"... Many of the factors that favor a satisfactory response to these drugs are also those clinically associated with the expectation of a good reaction to ECT. The danger lies in their general slowness in taking effect which makes their use hazardous for severely depressed suicidal patients who, preferably, should be treated with electroshock therapy. Otherwise, these compounds can be a satisfactory substitute for shock therapy for most depressed patients. Thus, these drugs have lessened the need for ECT. On those occasions when ECT is necessary, if the shock therapy is combined with an antidepressant, ECT can be dispensed with after a few treatments."



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EXCERPTS FROM A SYMPOSIUM ON DEPRESSION (continued)

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AMITRIPTYLINE HYDROCHLORIDE

INVESTIGATOR	FINDINGS
DORFMAN, WILFRED: Masked depression.	"In evaluating the effectiveness of amitriptyline in all these different settings, it was considered to be effective in 17 of the 25 patients (68%)."
FELDMAN, PAUL E.: Psychotherapy and chemotherapy (amitriptyline) of anergic states.	"Compared to other energizer compounds, particularly the hydrazines, amitriptyline appears to be relatively nontoxic. The laboratory reports for the most part remained within normal limits. Occasionally, abnormal readings were reported, but these appeared only sporadically and were not related to any clinical findings."

INDICATIONS: manic-depressive reaction—depressed phase; involutional melancholia; reactive depression; schizoaffective depression; neurotic-depressive reaction; and these target symptoms: anxiety; depressed mood; insomnia; psychomotor retardation; functional somatic complaints; loss of interest; feelings of guilt; anorexia. May be used whether the emotional difficulty is a manifestation of neurosis or psychosis,[1] and in ambulatory or hospitalized patients.[1,2,3]

USUAL ADULT DOSAGE: Tablets – initial dosage 25 to 50 mg. three times a day, depending on body weight, severity, and clinical disturbances. Dosage may be adjusted up or down depending upon the response of the patient. Some patients improve rapidly, although many depressed patients require four to six weeks of therapy before obtaining antidepressant response. For the ambulatory patient the dosage range for Tablets ELAVIL is 40 to 150 mg. daily. In the hospitalized patient, a daily dosage up to 300 mg. may be required. Injection ELAVIL may be given IM to rapidly calm depressed patients with symptoms of anxiety and tension while instituting therapy of the underlying depression. Initial therapy is 2 to 3 cc. (20 to 30 mg.) IM, q.i.d.

The natural course of depression is often many months in duration. Accordingly, it is appropriate to continue maintenance therapy for at least three months after the patient has achieved satisfactory improvement in order to lessen the possibility of relapse, which may occur if the patient's depressive cycle is not complete. In the event of relapse, therapy with ELAVIL may be reinstituted.

ELAVIL is not a monoamine oxidase (MAO) inhibitor. It does, however, augment or may even potentiate the action of MAO inhibitors. Thus, in patients who have been receiving MAO inhibitors, ELAVIL should be instituted cautiously after the effects of the MAO inhibitors have been dissipated. No evidence of drug-induced jaundice, agranulocytosis, or extrapyramidal symptoms has been noted. Side effects with ELAVIL are seldom a problem and are not serious. They are dosage-related and have been readily reversible. Side effects (drowsiness, dizziness, nausea, excitement, hypotension, fine tremor, jitteriness, headache, heartburn, anorexia, increased perspiration, and skin rash), when they occur, are usually mild. However, as with all new therapeutic agents, careful observation of patients is recommended. As with other drugs possessing significant anticholinergic activity, ELAVIL is contraindicated in patients with glaucoma, prostatic hypertrophy and urinary retention.

SUPPLY: Tablets, 10 mg. and 25 mg., in bottles of 100 and 1000. **Injection** (intramuscular), in 10-cc. vials, each cc. containing 10 mg. amitriptyline hydrochloride, 44 mg. dextrose, 1.5 mg. methylparaben, 0.2 mg. propylparaben, and water for injection q.s.

REFERENCES: 1. Ayd, F. J., Jr.: Psychosomatics 1:320, Nov.-Dec. 1960. 2. Dorfman, W.: Psychosomatics 1:153, May-June 1960. 3. Barsa, J. A., and Saunders, J. C.: Am. J. Psychiat. 117:739, Feb. 1961.

Before prescribing or administering ELAVIL, the physician should consult the detailed information on use accompanying the package or available on request.

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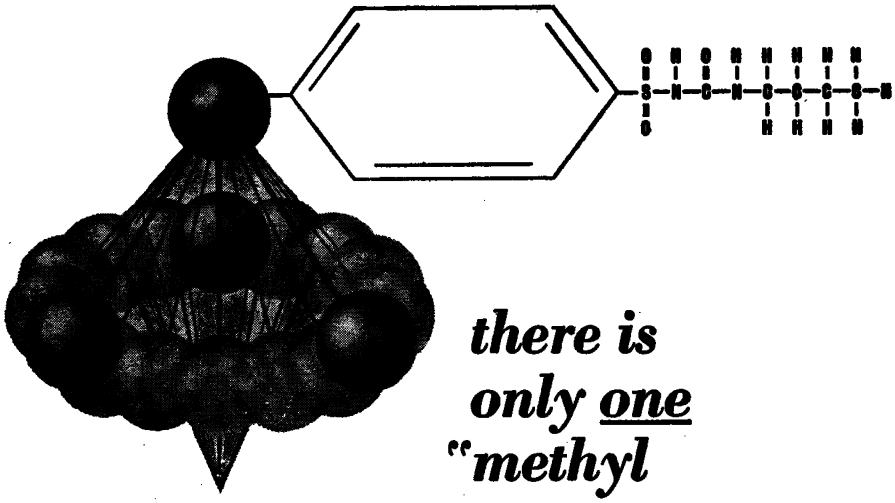

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